APPENDIX TO COUNCIL MEETING MINUTES

October 20, 2005

From: Friends of Fircrest
Action for RHCs
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Purpose: Testimony
To: The Statewide Developmental Disabilities Residential Services Council

Dear Council members and staff:

Inherent in the Council's mandate, to recommend a preferred system of services, is the challenge to retain and build upon what is excellent in the existing system while innovating to meet the widely diverse needs of the DD population. We of Friends of Fircrest and ACTION For RHCs are heartened by the potential to finally have complete and accurate data with which this Council, as well as policy and lawmakers, can base crucial decisions which will govern the future well-being of our loved ones with developmental disabilities.

In support of these goals, we strongly urge the following:

- Fair and objective recommendations for placement and services for the full spectrum of DDD clients, statewide, including those who require the safety and individualized, intensive medical and behavioral support available in all 5 RHCs.

-Recognition that not everyone can live successfully in the Community and that, according to the Olmstead Supreme Court decision, for some, RHCs are the least restrictive setting.

- Recommendations must be based upon thorough and accurate data obtained from a credible, unbiased
study. (ie: by the Policy Consensus Center of the UW/WSU.)

- Sufficient time for a complete and meaningful study to be designed, the data collected and assessed, and then, the council's recommendations to the legislature to be formulated.

RECOMMENDATIONS FOR THE 2005 STUDY ON STATEWIDE DEVELOPMENTAL DISABILITIES POPULATION NEEDS AND RESOURCES

To assure credibility, the study must be conducted by neutral, outside, agency unaffiliated with DSHS or any biased entities. (Eg: Policy Consensus Center.

I: **Comprehensive needs analysis of all DDD clients in the community** must be

done:

(*Do not use "CARE" assessment tool, as this tool was not designed for the DD population and too often does not accurately portray the client's actual limitations and needs.*)

A. Client wellbeing

1. Existing relationships, family, guardian proximity, client familiarity with caregivers, environment.

2. Safety

a. (from harm: accidental or inflicted by self or others. *(Many who reside in RHCs require intensive programs to keep self and others safe. Many have been failed previously in community placements, but have thrived within the safe programs and environment of RHCs.)*

b. Look at what incentives there are for contractors to keep clients safe: auditing; standards; consequences for failing audits - safety implications of state assuming liability costs for clients of private contractors.

B. Types of services needed.

1. work programs
2. day programs
3. special education
4. therapies (physical, speech, occupational, dietary, behavioral
g. adaptive technologies
5. environmental modifications (safety features such as fences, locks, adaptive equipment, wheel chair accessibility, building reinforcement
6. social supports
7. proximity of guardians for exercise of duties: oversight and participation in decision making
8. health management
(Physician care, Nursing Care, attendents or nurses aids, pharmaceutical expertise, proximity to needed healthcare facilities)
9. transportation (type, frequency, availability, number of attendants required
10. respite care: crisis and planned
11. Transitional care
12. Admissions for medical and behavioral management (These are services for which RHCs are better equipped than hospitals, and, when compared, RHC costs are much lower. Also, when the individual has mental retardation, the services can be expected to be more appropriate in RHCs.
13. Dental care.

C. Levels of service required.

1. Intensive:
Extreme mental and/or physical, medical, psychiatric and/or behavioral disability. (Intensive services available at RHCs. Many

already tried community alternatives but without success.
2. Minimal assistance required for some living in community settings
3. The full spectrum in-between

II: Needs projections:

A. Consider the rise in autism

B. Analyze long-term effects of aging on the developmentally disabled population;*

C. Others:

D. determine what will be required:

1. types of services,
2. environments. (Safest, least restrictive which include supports for self help, socially sustaining)
3. collective expertise including specialized direct care staff.

IV: **Full, accurate accounting of all of the costs of community care**. (The costs of RHC care and services are already available.) (2002 JLARC performance audit of DDD established that large percent have not been accounted for.)

A. Cost analysis must include but not be limited to:

1. Funding External To DSHS:

K-12 (2002-2003) school year: "each special education student generates state basic education, state special education and federal special education funding of $9090." " During the school day, these children are primarily the 'clients' of the school system". *(JLARC Performance Audit of DDD of December /2002)*

"DDD clients also receive services in Vocational Rehabilitation, Aging and Adult Services, Division of Alcohol and Substance Abuse, and Juvenile Rehabilitation. *(JLARC Performance Audit of DDD of December /2002)*

B. Other Parts of DSHS Funding Not Accounted For in DDD budget :

1. Acute Medical Services represent 32% of the DDD Budget not accounted for. *(JLARC Performance Audit of DDD of December /2002)*

2. 81% of DDD clients receive additional funding from other parts of DSHS;

a. Mental Health Division (MHD)

b. Economic Services Administration (ESA)

c. Children and Family Services (DCFS)

"These costs can greatly exceed the expenditures for services from the DDD budget." *(JLARC Performance Audit of DDD of December /2002)*

C. Cost of allowances for room and board for community clients.

D. Look at the assumption of risk by contractors. What is the cost to insure that risk, if any, to contractors? to the state?

V: **Comparative analysis**

Using the new, accurate accounting of the community costs, a comparative cost analysis between RHC clients'costs and Community clients' costs must be done. It must compare costs of similar clients with similar services, programs, and liability coverage etc. in each venue. Room and Board costs must either be included in both venues or excluded from both venues. (It is misleading to make comparisons by averaging the costs for the mixed populations in each venue.

VI. Assess potential cost savings of utilizing services sited at RHCs for non-RHC residents.

VII. Assess feasibility of obtaining provider numbers for RHC outpatient services in order to remain in compliance with Medicaid law while providing outpatient services.

VIII: Assess client and family desire for RHC and community placement. Include in discussion: all options including RHC placement and what is offered in RHCs.

IX: Staffing

A**.** Levels of training and experience required to provide the needed quality of the needed services.

B. Turnover vs continuity of care: Assess impact of caregiver turnover and determine how to mitigate where it is high.

C. Assess the problems of understaffing or under-qualified staffing.

X: Oversight, standards, monitoring and compliance:

A. Assess

1. current auditing systems and their impacts, positive or negative on developmentally disabled clients.

2. What is needed to assure that standards for optimal safety, care and services are in place and that they are met? *(The system which governs RHCs could serve as a standard of excellence in that the auditing standards are strict and compliance is assured by the threat ofwithdrawal of funding.)*

3. Consider the consequences to clients if high standards are not defined, audits are not strict or compliance is not enforced with serious consequences

to provider.

B. Provide quality assurance recommendations to Council

XI: Determine where needs can be met most effectively and cost effectively:

A. Assess Physical Facilities (include community placement options as well as all RHCs):

1. Best Cost Value in terms of which sites offer the best infrastructure condition, potential for multi-use (defer other state, lease costs), and multiple, residential, building construction types that support both ICF/MR and SNF certification.
2. Availability of needed services.

B. DD population demographics including what kinds of services are needed and which are available or in need of development in which locations.

C. Consider possibilities for use of unused parts of RHC properties for generating income and/or for saving money which could be used to stretch the state's ability to provide the needed services. Suggest possibilities for such uses which could compatibly coexist with the RHC.

(Do not use assumptions and data from the 2002 JLARC Land Use Study; it was extremely flawed.)

*A percent of the Baby Boom populaiton is DD. A percent of them can be expected to age more rapidly with attendent age related problems, requiring DD expertise as well as medical expertise.

**Optimal operating capacity balances economy of scale from larger populations against maintenance and capital upgrade costs, which rise with increasing populations.